EXECUTIVE SUMMARY

of the

ROYAL COMMISSION
ON
HOSPITAL AND NURSING HOME COSTS

February 15, 1984

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Introduction

The Royal Commission on Hospital and Nursing Home Costs was created on April 15, 1983, with a duty to report by February 15, 1984, on the reasons for increasing costs in hospitals and nursing homes and on the efficiency or otherwise of these institutions. The Commission was requested to make recommendations for improved efficiency, for the generation of additional revenue, if required, and to project the costs of the health care delivery system for the next five years. The Commission's full report contains 217 recommendations, a complete listing of which is attached to this summary.

Health Care Costs

In 1983/84, the cost of operating all the Province's hospitals will exceed $320 million. In 1972, hospitals spent less than $60 million. Nursing home operating costs will exceed $50 million in 1983/84, compared to $5.4 million in 1973/74. Over the last ten years, hospital and nursing home costs have increased by over $300 million, an increase in excess of 450%. The Commission's report contains a detailed review of the factors underlying such increases, but the following are felt by the Commission to be the major contributors:

Increase in Hospital Personnel

The last ten years have brought significant changes in the numbers and types of hospital personnel. Since 1974, the number of hospital staff (including contract service employees) has increased by 44%, from 7,335 fulltime equivalent employees to 10,527 in 1983/84. One in every 17 employees in the Province now works in a hospital. The Commission estimates that of the 1983/84 expenditures, in excess of $70 million can be accounted for by these additional personnel.

Increase in Salaries and Benefits

Most submissions to the Commission suggested that salary and wage rate increases have been the most significant influence driving up hospital and nursing home costs. Clearly, in such a labour intensive industry, changes in remuneration will lead to corresponding changes in operating costs.

The salary changes over the last 8 to 10 years have contributed significantly to increased costs. The Commission estimates that, after allowing for additional personnel, salary and benefit changes since 1972 account for approximately $120 million of current 1983/84 expenditures. This estimate includes all changes in salaries, fringe benefits and collective agreement provisions such as callback, overtime, severance pay and the like. The salary rate changes of course account for the bulk of the increase. Since 1974, salaries paid to nurses have increased by 185%, and since 1975 support staff salaries have increased by an average 126%, laboratory and radiology rates by 150%, and allied health professional salaries by 111%. The average management salary increased by 136% between 1975 and 1983.

The salary-related benefits such as overtime and callback received a considerable amount of attention during the Commission's hearings. While these have increased in absolute amounts, as a percentage of salary costs salary-related benefits have remained relatively constant. In 1979/80, these benefits represented on average 5.4% of salaries, while in 1982/83, the average was 5.7%. However, even this apparently minor percentage increase adds over $600,000 to current costs.

Of more significance in the benefit package is the increased cost to the employer of benefits such as group insurance, workers' compensation, and pension plans. In 1973, $1,738,500 was spent on these benefits. It is estimated that 1983/84 costs will approximate $17 million. Such benefits as a percentage of total operating costs have gone from 2.6% in 1973 to 5.4% in 1982/83.

Additional Physicians

While it has not been possible to quantify the proportion of increased hospital costs traceable directly to a greater number of physicians, the Commission has concluded that increased physician supply is a significant factor in the rising unit costs of hospital services. Between 1976 and 1981, the number of actively practising physicians, both specialist and nonspecialist, increased by 30% from 586 to 766. Statistical analysis indicates that in particular an increase in the number of specialists is a key variable in the greater allocation of resources for each unit of output.

Additional Nursing Home Beds

In 1974, the Province was served by twelve (12) nursing homes with 1,065 beds. By 1983, total beds had increased by over 90% to 2,058 located in twenty-three (23) homes. The

Commission estimates that these additional beds add approximately $29 million to current operating costs.

Other Service Benefits

The benefits derived from such a substantial increase in the consumption of health care resources are difficult to assess. Hospital utilization expressed in separation and patient days per 1,000 population is declining, although the total volume of service provided (expressed in patient days) has remained relatively constant. The patient day alone is not an adequate indicator of hospital service volumes and intensity. An increasing number of services are being provided on an outpatient or ambulatory basis; approximately 881,000 ambulatory visits were recorded in 1976, and the number is expected to approach 975,000 in 1983/84.

There has been little change in the total number of hospital beds, going from 3,045 general hospital beds in 1972, to 3,285 beds in 1982/83. There have been changes in the distribution of beds, new facilities being built at Carbonear and at the Health Sciences Centre and some smaller institutions being closed. Likewise, the number of special care unit beds has increased while general obstetric and pediatric beds have been reduced.

Even given the increased emphasis on ambulatory care, however, the Commission cannot attribute a significant portion of the cost increase to a greater quantity or volume of care. Much of the cost increase can be attributed to a greater intensity of service; i.e., more resources per unit of output. A study done for the Commission by a staff member of the Economic Council of Canada concluded that the trend towards greater "task intensity" was more pronounced in Newfoundland than in the rest of Canada. For example, over the past twenty

years, nursing hours per patient day have increased from two to over six, nursing hours per delivery from less than five to over twenty, and nursing hours per newborn day from less than two to over four.

It is not possible to measure whether patients hospitalized today are more severely ill than those of ten or even five years ago. The morbidity statistics contained in the report show a fair degree of consistency in the leading causes of hospitalization from 1970 to 1980/81, the most frequent admitting diagnosis in every year being "Delivery Without Mention of Complication". Perhaps the most significant indicator of improved health is the marked decline in infant mortality which, since 1951, has been reduced from 54.4/1,000 live births to 9.7 in 1981. This is no doubt due in large measure to concerted efforts in public health, prenatal and neonatal intensive care.

New service programs have added substantially to hospital costs. Coronary bypass surgery costs an estimated $20,000 per procedure, and at the current rate of 300 operations per year requires $6 million annually. A patient on renal dialysis for a year will consume resources costing between $33-48,000, depending on the type of dialysis. Other programs, such as the neonatal intensive care facility at the Janeway Child Health Centre, which has been instrumental in reducing the infant mortality rate, consume substantial additional resources.

Efficiency and Level of Funding

There is significant potential for improved efficiency in the Province's hospitals and, to a lesser extent, in nursing homes. The amount of potential savings cannot be precisely

determined, but through a combination of a planned reduction of unoccupied beds and institution of the efficiencies and budgetary modifications recommended, we believe that a minimum of $20 million savings can be realized at present service levels. In addition, there are clinical and economic efficiencies to be achieved in the longer term through a commitment to both sound planning and a rationalization of institutional services.

The Commission was invited by the Newfoundland Hospital Association to compare the current costs of operating Newfoundland hospitals with those experienced in Nova Scotia. Although this is of course only a very broad indicator which itself assumes that Nova Scotia's hospitals as a whole are operated efficiently, preliminary Statistics Canada data for 1982/83 indicates a per patient day cost for general nonspecialty hospitals of $324.88 in Newfoundland and $285.18 in Nova Scotia. At current patient day volumes in Newfoundland, the difference amounts to nearly $32 million.

The savings possible in Newfoundland cannot be achieved immediately. If present service levels are to be maintained, operating funds cannot be reduced arbitrarily and time must be given to develop and institute the organizational and other changes that are necessary. Some adjustments will, of course, take longer than others and the results may be evident in a lower rate of subsequent cost increase than in absolute savings.

At present service and program levels, the Commission believes that there is currently enough money available overall in the hospital and nursing home system for the 1984/85, and, at least in hospitals, probably for the 1985/86 year. This excludes any additional funding required for salary and wage increases.

Future Costs

The Commission was asked to project the operating costs of the health care system for the next five years taking into account Government's plans for new and expanded hospitals and nursing homes. Such projections necessarily rely on a detailed analysis of past trends and experience and require that certain assumptions be made about the future. A complex mathematical model was developed to assist in this task and to provide a working tool which could be transferred to Government for its further development and use. This model enables the impact of changes in a variety of resource input variables to be assessed and the resulting costs estimated.

It will, of course, be realized that any estimates of future costs represent a "best effort" and that unforeseen changes in one or more major variables or in the interrelationship between the variables will have a significant impact on the accuracy of the estimates.

If services, facilities, and manpower expand as presently planned and in accordance with established trends (and assuming for calculation purposes only wage rate increases of 3%, 3%, 4%, 4%, and 5%), the Commission estimates that in 1988/89 the cost of operating the Province's hospitals and nursing homes will be $630 million. If the wage rate increases in the last three years are assumed to be 2% higher per year, the estimated 1988/89 costs rise to $656 million. These projected cost figures include the operation of the new hospitals in Clarenville and Burin which, at present estimates, will each cost in excess of $8 million annually to operate.

The Commission estimates that full implementation of its recommendations will result in 1988/89 operating costs of less than $600 million. This assumes the provision of 700

additional nursing home beds, three community health centres and increased regional home support services, together with the closure of approximately 350 unutilized general hospital beds. We have not been able to estimate the potential operating savings from the rationalization of services in St. John's, and accordingly such savings, when realized, will further reduce the estimated operating costs.

Fiscal Capacity and Revenue Generation

The Province does not have the fiscal capacity to meet all demands and requests for additional health care facilities and other resources. Some needs, such as that of institutional and other care for the elderly, will have to be met; others, such as requests for duplication of expensive technology and services probably should not be met. The first step in any issue of resource allocation must be to extract maximum efficiency and cost-effectiveness from current expenditures. Many of the Commission's recommendations are directed to this objective. If further action must be taken, the choices are a reduction in service levels, an increase in revenue or a combination of the two.

The Commission does not believe that the current user fees are an appropriate mechanism for generating material revenue. Apart from the difficulties raised by the Canada Health Act, user fees generate minimal net revenue and detract from the basic principles of the publicly funded health system. The Commission has suggested other options for the general raising of necessary revenue, including a payroll tax and a personal income surtax.

Should a decision be made to reduce services, the Commission believes that the most effective method of

accomplishing such a reduction would be by a program of bed closures carried out on a regional basis, leaving the institutions and regions to determine, in consultation with Government, the specific service programs which would be affected. In addition, and preferably before any existing beds are closed, decisions should be taken not to open and operate new facilities presently under construction.

Major Recommendations

The recommendations made by the Commission should be regarded as a comprehensive program for addressing the rising cost of health care delivery. Some recommendations are, in the Commission's judgment, more significant than others and these have been outlined below. The reader is requested to refer to the complete text of the recommendations and the report in order to be aware of the interrelationship between and the reasoning behind the recommendations.

The Commission considers the following to be among the major recommendations:

1. That in certain geographic areas, including St. John's, provision be made for cross-representation on the Boards of Management of hospitals and nursing homes and on the Medical Advisory Committees of hospitals. (Recommendations 4.4 and 4.5.)

2. That a detailed bed study be conducted by Government with a view to reducing the number of general hospital beds available to meet present service levels by 355. (Recommendation 4.7.)

3. That an incentive program be established under which hospitals and nursing homes may retain a portion of operating savings, with the balance of such operating savings being used to fund a provincial health care research foundation. (Recommendations 4.66 and 4.86.)

4. That those provisions of collective agreements having a direct or indirect impact on costs, other than salaries and wages, be maintained at their present levels until March 31, 1986. (Recommendation 4.80.)

5. That the monthly stipend payable to first and second year nursing students be eliminated and annual tuition fees instituted. (Recommendation 4.99 and following.)

6. That the multi-unit management concept as it relates to the management of hospitals and nursing homes in the same geographic area be adopted and extended. (Recommendation 4.110 and following.)

7. That the St. John's Hospital Council be appropriately funded and charged with the responsibility of developing a comprehensive plan for the delivery of health care services in St. John's, that such plan be required to maintain existing total acute short-term general hospital bed numbers up to the year 2000 and to stipulate that major construction or renovation be permitted at a maximum of two sites, and that until such plan is developed and submitted, no expenditures be committed for expansion or major renovation. (Recommendation 4.116 and following.)

8. That for the three fiscal years commencing April 1, 1984, the total budget (excluding education) allocated to that group of hospitals consisting of the General Hospital, St. Clare's Mercy Hospital, Grace General Hospital, Janeway Child Health Centre, and Children's Rehabilitation Centre, be frozen at the total 1983/84 budget allocation level (excluding education) with adjustments only for salary and related benefit increases. (Recommendation 4.121.)

9. That effective April 1, 1984, the $5 per day user fee be abolished. (Recommendation 4.124.)

10. That three pilot project community health care centres be established in Baie Verte, Botwood, and Mount Pearl. (Recommendation 4.151.)

11. That one universal rate be established for all private paying residents of nursing homes. (Recommendation 5.1 and following.)

12. That Government develop plans for the construction of a total of 700 additional nursing home beds to accommodate present and future needs for nursing home residents requiring high level nursing care. (Recommendation 5.15.)

13. That assessment of applications for admission to nursing homes be conducted by regional multi-disciplinary assessment teams on the basis of provincial criteria. (Recommendations 5.17 and 5.18.)

14. That long-term care Boards be established and funded on a regional basis to coordinate and facilitate the delivery of home support programs and services. (Recommendation 5.19.)

15. That a minimum of $1 million increased funding be made available for home support programs and services. (Recommendation 5.23.)

16. That by April 1, 1985, jurisdiction for all nursing homes in the Province be transferred to the Department of Health. (Recommendations 5.39 and 5.40.)

17. That the 1984/85 total budget allocation for all hospitals outside St. John's and for all nursing homes in the Province be established at the same level as the 1983/84 budget, with adjustments only for salary and related benefit increases. (Recommendations 6.1, 6.2 and 6.3.)

18. That if after achieving all potential efficiencies, available funds are insufficient to fund desired services, planned facilities not be opened and additional savings required be generated through bed reductions administered on a regional basis. (Recommendations 8.1, 8.2, and 8.3.)

19. That the viable options for consideration by Government for generation of revenues are a payroll tax, a personal income surtax and a corporation capital tax. (Recommendation 9.1.)

The Challenge of the Future

The provision of health care to the residents of Newfoundland requires a complex array of skills, services and facilities. To achieve maximum effectiveness and efficiency, the different components of the health care system must mesh in

an orchestrated pattern which is governed by the principles of a caring society set out in Chapter 3 of the Commission's report. Just as one facet of the system interacts with others, so do the Commission's various recommendations interact with each other. Few of the recommendations can stand alone, and acceptance of some recommendations and rejection of others would leave at risk the possibility of achieving the organizational and other changes required.

The implementation of the recommendations contained in the Commission's report will, we believe, require political courage and a not inconsiderable degree of political skill. The Commission believes that, at least to a certain extent, health care providers have accepted the need for major modifications in the organization and delivery of health care. Much will be expected and required of health care managers at both the senior and middle management levels. Some will be found to be not equal to the task and will have to be replaced. Others will respond eagerly and well to the challenge.

Hospitals and nursing homes are, for the most part, operated by voluntary community Boards. These Boards have provided a high level of services and the Commission sees no compelling reason to abandon the publicly funded community Board system in favour of private-for-profit facilities. However, and the Commission cannot state this strongly enough, the tendency to adopt protection of one's autonomy, image and identity as a dominant motivating concern must be eliminated. The Province cannot afford opposition to a rational delivery of service when that opposition is based on institutional pride rather than on patient care considerations. A number of the Commission's recommendations are directed to eliminating the present barriers to cooperation and integration and to providing some incentive to commence the innovative thinking that will be required.

The Commission's report concerns the future modes of organization and delivery of health services throughout the Province. We believe that the recommendations of the Commission are cost effective and are within the financial ability of the Province. We also believe that they are consistent with the philosophy of a caring society. The necessary changes will not come about easily. A renewed commitment to the care of the individual will be needed and entrenched attitudes and motivations must be modified. Consistent and firm guidance will be required from Government, and rational acceptance of rational decisions will be required from health care providers and consumers. We believe that Newfoundland and Newfoundlanders have both the resources and the will to make this possible.

LIST OF RECOMMENDATIONS

RECOMMENDATIONS INCLUDED IN CHAPTER 4
THE PROVISION OF ACUTE CARE SERVICES

The Commission recommends that:

4.1 Government undertake a public education program whereby the public is made aware of the competing demands for health care services, the inability of the Province to meet all competing demands, and the criteria used to assess the relative priority of competing demands.

4.2 Institutional Boards of Management conduct a realistic and mature self-assessment of the value to be placed on autonomy, identity and image in the context of meeting the health needs of the Province, and that each board ask itself the question: "If this institution were tomorrow to be operated by a completely different board or organization, would the services now being provided by the institution be affected, and if so, how?"

4.3 In allocation of resources and in future planning, the factors of identity, image and autonomy be considered relevant only insofar as they are established to enhance the quality of service available.

4.4 In certain geographic areas, the composition of hospital and nursing home boards be modified to require cross-representation; that is, one or more full voting members on any given hospital or nursing home board will also be full voting members of another hospital or nursing home board. The following are examples of how this recommendation should apply:

1. Grand Falls and Gander Hospitals: a minimum of one member each from the other board;

2. General, Janeway, St. Clare's, Grace and Waterford Hospitals: a minimum of two members each selected from the boards of the other four hospitals; e.g., the General Hospital Board may contain one Janeway member and one St. Clare's member;

3. Where a St. John's nursing home is board-operated, that board should contain a minimum of two members of another nursing home board.

   In each case, the choice of the member or members to be named to the board of another institution will rest with the board of that member; i.e., as in Example 2 above, the Janeway would select the member to be appointed to the General Board.

4.5 That in the hospitals referred to in Recommendation 4.4 above, the composition of the Medical Advisory Committee be modified to require cross-representation; that is a minimum of two members on the Medical Advisory Committee of each hospital would be a member of the Medical Advisory Committee in another hospital. In each case, the choice of the members to be named to the Medical Advisory Committee of another institution will rest with the board of the member.

4.6 In determining which particular combinations of cross-representation are appropriate for the St. John's hospitals, government solicit the recommendation of the St. John's Hospital Advisory Council.

4.7 (i) Within six months of the date of receipt of this report, a detailed provincial bed study be conducted and completed, which study would determine by region and by hospital:

(a) insofar as possible the role and service function of each region and hospital;

(b) the requirements for general hospital beds up to the year 2000;

(c) the potential for present reduction of beds to realize some of all of the savings attributable to the closing of 355 beds (or thereabouts, depending on the impact of the new facilities presently being constructed).

(ii) Such a study should take into account at least the following factors:

(a) trends in occupancy levels, particularly by size of hospital;

(b) projected referral patterns, taking into account the ability of smaller facilities to attract and retain specialist physicians, and the potential addition of new "subspecialties" based in St. John's;

(c) the impact of improvements in technology such as slow-scan video and other data transmission capabilities which may enable "remote" specialist consultations and reduce diagnostic admissions;

(d) the impact of possible changes in the physician fee schedule which may provide more appropriate remuneration for non-hospital-based and preventive services;

(e) the impact of improved home support services which may both lessen re-admissions and shorten the length of stay;

(f) the impact of further emphasis on day care, day surgery programs and short stay clinical investigation units;

(g) the impact of additional nursing home facilities and home support services which will reduce the number of medically-discharged chronic care patients occupying acute hospital beds;

(h) the impact of present and proposed "hostel" units on hospital admission and length-of-stay patterns;

(i) the establishment of a "target norm" for the number of acute hospital beds per 1,000 population. At present, following the reduction of 131 beds, the ratio stands at 5.4 beds per 1,000 for a population of 570,000. The planned addition of 90 beds will provide a ratio in excess of 5.5 for the same population. The reduction of 355 "excess" beds would, again for 570,000 population, leave total acute beds of 2,810 or 4.9 beds per 1,000. While not recommending any specific figure, the Commission believes that a figure

4.7 cont. lower than 4.0 is a reasonable type of figure to establish, and strongly recommends that such a figure in fact be established as a matter of policy in order to assist and ensure future rational planning. The Commission notes that the Province of Ontario has established a norm of 3.0 acute hospital beds per 1,000 population in Southern Ontario and 3.5 per 1,000 in Northern Ontario;

(j) the establishment of a minimum size for new hospital facilities. Again the Commission is not able to recommend a specific figure, but points out that inpatient facilities of 15-20 beds do not represent efficient delivery units from either an economic or a clinical point of view and that accessibility of quality care may be better provided through emphasis on clinic facilities with holding beds and stabilization capacity, improved transportation systems, and more widespread use by physicians of the "remote" technological assistance referred to above.

4.8 Until such detailed bed study is completed, no new hospital construction, expansion, or major renovation be commenced, committed, or planned. This freeze includes projects already in the planning stage. The Commission views it as absolutely essential to the most effective provincial use of scarce resources that commitments for additional and recurring operating expenditures be made only in accordance with established provincial priorities based on rational planning guidelines. To permit expansion, renovation and new construction because it is some particular institution's "turn" or

because of pressure created by the public or other groups will not provide the best affordable provincial health care system and may, in fact, destroy opportunities which exist for significant cost and clinical improvement through sharing of services and coordination between and amalgamation of various facilities, including both hospitals and nursing homes.

4.9 Once the new hospitals at Burin and Clarenville commence operation, the existing cottage hospitals at Grand Bank, St. Lawrence, Burin and Come By Chance be closed as inpatient facilities.

(i) It may be appropriate to establish one or more community clinics in these areas, but such clinics should be established only on the basis of demonstrated need and not in any way as "compensation" for the closing of the hospital facility. Any such clinics should not be independent but should become the responsiblity of the regional board, if any, for the area or of the board of the hospital with which the clinic will maintain its closest liaison. In addition, if new clinics are in fact to be established, the capital costs of constructing a new clinic as opposed to utilizing a closed cottage hospital must be carefully weighed against both the suitability of the structure of the cottage hospital to be adapted to the clinic facility and the additional operating funds, if any, which may be required if a less than desirable facility is utilized for clinic purposes.

(ii) Such cottage hospital facilities should also not be turned "automatically" into chronic care institutions. As discussed elsewhere in this

report, the provision of long-term care in Newfoundland must be subject to the same rational planning as the provision of hospital services and decisions to open chronic care facilities should be taken only when such planning has been completed and should be consistent with such planning.

Nursing

4.10 All hospitals having more than fifty beds institute a patient classification workload indexing system in order to:

(i) establish a base staffing level necessary to maintain the particular unit;

(ii) objectively assess on a per shift basis the nursing needs of each patient; and

(iii) on each unit and on each shift, match the additional resources required, if any, with those allocated, including specific attention to the level of nursing skills and qualifications required.

4.11 Such patient classification system be integrated with the nurse scheduling system and that all reasonable steps be taken to ensure flexibility of allocation of nursing staff. These steps should include but not be limited to:

(i) maximum use of part-time and casual staff to smooth out scheduling and to respond to workload fluctuations and unavoidable relief;

(ii) increasing orientation and training of nursing personnel to hospital units other than their "home" unit to facilitate in-house transfers on a shift basis which ensures that the patient continues to be cared for by a properly trained person and that the transfer is not viewed as threatening by the employee in question.

4.12 Until Recommendations 4.10 and 4.11 have been instituted and are operating to the satisfaction of the funding agency, no increase other than appropriate salary adjustments be given in any nursing unit budget.

Diagnostic Laboratory Services

4.13 All hospitals review off-hours coverage, both standby and regularly scheduled shifts, in order to critically reassess whether present availability of service is in excess of that reasonably required.

4.14 All hospitals institute a review of all standing orders and routine protocols for routine laboratory work with a view to re-examining and confirming the current medical necessity of such orders and that all such orders be re-examined annually.

4.15 In hospitals of one hundred beds or larger, information systems be developed to monitor inpatient and outpatient usage of laboratory facilities by individual physicians to assist in identifying diagnostic practice patterns which deviate significantly from those of other physicians.

4.16 All hospitals establish or reactivate existing committees, including medical staff membership, to:

(i) review significantly different physician patterns of laboratory utilization;

(ii) recommend to the Medical Advisory Committee which laboratory tests, if any, may not be ordered directly by house staff or any category thereof without prior approval of the attending physician, or by any particular category of physician, either on the hospital medical staff or otherwise;

(iii) review use of callback by staff physicians in order to provide an objective peer review of the medical benefits of the callback service compared to the cost of such service.

4.17 All hospitals institute programs whereby callback and overtime are monitored on a "real time" basis and in particular that the conditions under which house staff may initiate a callback request are clearly delineated and that all such requests are subjected to timely review by the attending physician.

4.18 As a guideline for any base budget review undertaking in hospitals of one hundred beds or larger, the amount allocated for staff salaries (excluding medical but including all overtime and callback, etc.) be set at a maximum of $.22 per unit (82/83 figures), and the amount allocated for supplies be set at a maximum of $.085 per unit unless there is a clear and compelling reason to establish a higher figure or figures in any given situation.

Diagnostic Radiology Services

4.19 All hospitals jointly conduct basic industrial engineering studies or draw on available data, if any,

to determine appropriate time and level of skills required to perform specific radiological procedures.

4.20 Based on the time required to perform each specific procedure and the anticipated numbers of each, appropriate staffing levels be determined.

4.21 The time taken by individual technologists to perform each specific procedure be regularly assessed and evaluated with a view to ensuring ongoing compliance with the standard times established.

4.22 Patient scheduling be arranged insofar as possible to reduce fluctuations in workload and to ensure maximum utilization of all staff time and that the cost benefit of extended operation, particularly for scheduled outpatient work, be examined.

4.23 All hospitals institute programs whereby callback and overtime are monitored on a "real time" basis and in particular that the conditions under which house staff may initiate a callback request are clearly delineated and that all such requests are subject to timely review by the attending physician.

4.24 All hospitals establish or reactivate existing committees, including medical staff membership to routinely review use of callback by staff physicians with the objective of providing an independent peer review of the medical benefit of the callback service compared to the cost of such service.

4.25 As a guideline for any base budget review undertaking in hospitals of one hundred beds or larger, the amount allocated for staff salaries (excluding medical but

including all overtime, callback, etc.) be set at a maximum of $.40 per unit (82/83 figures) and that the amount allocated for supplies be set at a maximum of $.15 per unit unless there is a clear and compelling reason to establish a higher figure or figures in any given situation.

Physical Medicine

4.26 In hospitals employing physiotherapists and/or occupational therapists, a standard guideline of paid hours per weighted unit be established for use in any base budget review undertaking. It is recommended that the following be the maximum acceptable figures:

Physiotherapy: 0.050 paid hours per weighted unit;
Occupational Therapy: 0.07 paid hours per weighted unit.

Medical Records and Library

4.27 Based on existing data relating to individual hospital performance and taking into account significant differences which exist, if any, between hospitals in the medical record and library research and teaching commitments, medical records and library staffing standards be established for individual hospitals as part of any base budget review undertaking. Such staffing standards should be such as in the short term (i.e., one to three years) to permit a provincial average per adult/child separation cost for hospitals of one hundred beds or greater of not more than $35, based on 1982/83 costs.

4.28 Hospitals be encouraged to investigate the cost benefit of increased automation and computerization of record creation and retrieval, and that the necessary budgetary flexibility be provided to allow for the amortization of the capital costs of such equipment over a reasonable period of time as a charge against operating expenses.

Medical Surgical Supplies and Drugs

4.29 There be improved inventory and usage controls for medical and surgical supplies with a view to monitoring unit use of these items and making such patient and cost centres accountable for their usage.

4.30 Where not already established, product standardization committees be established to ensure that all unnecessary duplication and inappropriate "personal preference" supplying is eliminated.

4.31 In-house "cost awareness" educational programs be implemented to educate medical, nursing and other staff on the cost of medical/surgical supply items.

4.32 If the Commission's recommendation concerning the overall budgeting for the St. John's hospitals is not accepted, for the three fiscal years commencing April 1, 1984, but excluding necessary supplies for home and hospital-based renal dialysis, total hospital budgets for drugs and medical and surgical supplies be frozen at the 1983/84 budget level for the General, Grace, St. Clare's and Janeway Hospitals.

4.33 All hospitals of one hundred beds or larger develop through the Pharmacy and Therapeutics Committee a "Drug Privilege Program" in which high-cost drugs are

identified and the prescription of which are restricted to specified physicians. Nonspecified physicians prescribing a listed drug would require the prior approval of a specified physician. It is further recommended that the lists of drugs so developed be circulated among the hospitals in order to ensure as much uniformity as possible.

Administration

4.34 All hospitals immediately conduct a detailed review of all management and supporting secretarial positions, including those in nursing and other departments, to determine what opportunities exist for reduction of personnel by a sharing of duties and by adopting a flatter organizational pyramid.

4.35 The Newfoundland Hospital Association continue to develop its trustee education program with emphasis on the role and evaluation of the Chief Executive Officer, the measurement of clinical and management efficiency, and the regular review of the effectiveness of all hospital programs, and that such trustee education program be mandatory for all trustees in their first year of appointment and every third year thereafter.

4.36 Hospital Boards of Management be encouraged and assisted to set minimum qualifications required for their various administrative personnel and to require mandatory continuing education.

4.37 Hospital boards immediately establish guidelines for evaluating the performance of senior management personnel and conduct regular annual evaluations of such personnel, and that boards require their administrator

likewise to establish guidelines for and regularly evaluate all other management personnel.

4.38 All hospitals with more than fifty beds be required to participate in the Quarterly Hospital Information System, and further that all hospitals in the Province provide annually to the Newfoundland Hospital Association for distribution to its members copies of the Annual Return of Health Care Facilities immediately upon completion of same.

4.39 All hospitals having chiefs of clinical departments develop a formal mechanism whereby these physicians participate in regular reviews of the use of resources by their clinical area, such resources being inclusive of, but not limited to, beds, nursing, diagnostic services, medical and surgical supplies and drugs. It is recommended that the time spent by fee-for-service physicians on such management matters be paid for by the hospital on an agreed sessional basis. It is further recommended that the incentive program outlined by the Commission be decentralized within each institution where appropriate and that clinical departments be afforded the opportunity of benefiting from such program where retained savings are directly attributable to improved utilization of resources by that department.

4.40 Where geographic proximity or technology renders it feasible, hospitals and nursing homes immediately adopt a principle and policy that administrative (and support) services and functions be coordinated and shared where at all possible between hospitals, nursing homes and hospitals/nursing homes, such functions to include, but not be limited to, personnel functions for all categories of staff, staff education and development,

and computerized accounting and record keeping, and that steps be instituted immediately to identify and put into place potential shared services.

Dietary

4.41 Each institution utilizing a dietary service contract conduct a critical immediate review of such contract service in order to assess whether equivalent services can be more economically provided in-house.

4.42 All renewals or initiation of dietary service contracts be tendered where competing suppliers are available.

4.43 Increased emphasis be placed on orientation and in-service education for both dietary management and dietary service workers with a view to improving management techniques and increasing the efficiency and productivity of service personnel.

4.44 Where geographic proximity renders it feasible, hospitals and nursing homes immediately adopt as a priniciple and policy that dietary services be coordinated and shared between hospitals, nursing homes and hospitals/nursing homes.

4.45 As a guideline for any base budget review undertaking in hospitals of one hundred beds or larger, the amount allocated for staff salaries in the dietary department be set at a maximum of $8 per meal day (1982/83 figures), unless there is clear and compelling reason to establish a higher figure in any given situation.

Housekeeping

4.46 Each institution utilizing a housekeeping service contract conduct a critical immediate review of such contract service in order to assess whether equivalent service can be more economically provided in-house.

4.47 All renewals or initiation of housekeeping contracts be tendered where competing suppliers are available.

4.48 Increased emphasis be placed on orientation and in-service education for both housekeeping management and housekeeping service workers with a view to improving management techniques and increasing the efficiency and productivity of service personnel.

4.49 Where geographic proximity renders it feasible, hospitals and nursing homes immediately adopt as a principle and policy that housekeeping services be coordinated and shared between hospitals, nursing homes and hospitals/nursing homes.

4.50 An immediate review be made in all institutions of housekeeping functions and duties, including their frequency and number of manhours properly expected to perform each function; and that housekeeping managers be required to design and implement formal housekeeping scheduling systems based on such tasks being performed at regular intervals and to acceptable standards of quality and efficiency.

Linen and Laundry

4.51 All hospitals review their policies and practices with respect to utilization of linen, particularly with

respect to routine bed changes and other linen usage based on practice rather than on need, with a view to reducing utilization to a maximum of twelve (12) pounds per patient day.

4.52 A target cost per pound (1982/83 costs) of a maximum of $.40 be established for those facilities serviced by Central Laundry, and that an immediate and critical assessment of Central Laundry be undertaken with that facility being compared with those in Corner Brook, Gander, and Grand Falls to establish and isolate the significant variances in unit costs and the reasons therefor.

4.53 Where geographic proximity renders it feasible, hospitals and nursing homes immediately adopt as a principle and policy that laundry and linen service be coordinated and shared where at all possible.

4.54 Where a regional, centralized or other laundry service external to the institution is reasonably available at a lower cost than that presently incurred or attainable by the institution itself, the institution be funded only for such lower cost.

Plant Operation and Maintenance

4.55 All hospitals conduct an immediate "zero base" review of all positions in Plant Operation and Plant Maintenance, with a suggested specific objective of reducing personnel costs by at least fifteen (15%) percent in the Plant Maintenance Department.

4.56 Maintenance supervisors be required to implement a scheduled preventive maintenance program and a

controlled work order maintenance response program which identifies the skills required to meet a particular request, estimates the manhours to complete the request and provides for compilation and review of manhours spent on each such request.

4.57 All hospitals and nursing homes immediately plan and implement an energy conservation program, and that the necessary budgetary flexibility be provided to allow for the amortization of the capital cost, if any, of such a program over a reasonable period of time as a charge against operating expenses.

4.58 Where relevant, institutions examine the technical practicality of installing failsafe mechanisms on high pressure vessels, that the necessary legislative amendments be made to eliminate the requirement for shift engineers when such failsafe mechanisms are installed, and that the necessary budgetary flexibility be provided to allow for the amortization of the capital cost, if any, of such a mechanism over a reasonable period of time as a charge against operating expenses.

4.59 Where geographic proximity renders it feasible, hospitals and nursing homes immediately adopt as a principle and policy that maintenance services and maintenance contracts be shared and coordinated to the fullest extent possible between hospitals, nursing homes and hospitals/nursing homes.

4.60 Where specialized maintenance programs are required, hospitals critically assess the cost benefit of contracting out such services either on an individual or shared basis.

Financial Management

4.61 The Department of Health's current policy of "no deficit" funding be continued.

4.62 The Department of Health's current policy of global budgeting be continued.

4.63 Hospitals be advised of their operating budget for each financial year no later than March 1 preceding commencement of that year.

4.64 Except in the case of program or service reductions or other planned and agreed modifications to a hospital's role or in the case of a baseline review, the budget for any financial year not be reduced because of savings in the preceding year or years.

4.65 Present budgetary policy be amended to allow hospitals to amortize the cost of capital expenditures as a charge against operating expenses over a reasonable payback period, not exceeding in any event five (5) years. It is intended that this flexibility should operate only in situations where a present capital expenditure will result in future operating savings which when aggregated over the payback period in constant "year of purchase" dollars will equal or exceed the amount of the capital expenditure. Such capital expenditures shall be made from existing hospital funds, shall require prior Department of Health approval, and shall not obligate or commit the Department of Health to approve any future expenditures, either operating or capital.

4.66 Effective the fiscal year ending April 1, 1984 (i.e., the current year) and thereafter, the following

4.66 cont. incentive plan be adopted and, if required, the necessary changes to the Financial Administration Act be made:

(i) Of the first $50,000 savings in any year, accredited hospitals and nursing homes only shall be permitted to retain 100% of such amount.

(ii) Of the second $50,000 savings in any year, accredited hospitals and nursing homes only shall be permitted to retain 75% of such amount.

(iii) Of savings in excess of $100,000 in any year, accredited hospitals and nursing homes only shall be permitted to retain 50% of such savings.

(iv) The total savings in any one year shall be based on the agreed final settlement figures and shall not in any event include savings attributable to labour disputes or other events, foreseen or unforeseen, leading to a reduction of planned service levels.

(v) The conditions for retention of savings in any given year shall include the following:

(a) the meeting of all financial and other reporting requirements reasonably set by the funding agency;

(b) the submission of a full and detailed report to the funding agency by March 31 in each year outlining the disposition of the savings, if any, for the financial year ended the previous March 31;

(c) the maintenance of accreditation throughout the whole of any year for which savings are claimed;

(d) the maintenance of all approved service and educational programs within the volume ranges previously agreed between the institution and the funding agency;

(e) the institution and maintenance of a system of critical program evaluation whereby all service and educational programs are reviewed and assessed at least annually, and whereby positive decisions to continue or not continue each service program are made annually based on the assessed benefit and cost of such program, the alternative sources, if any, of such program, the alternative methods, if any, of delivery of such program, and evaluation of such program against any established and agreed, but unfunded, priorities of the institution.

(vi) The institution's use of retained savings shall be unrestricted except that:

(a) new service or educational programs shall require the prior approval of the funding agency;

(b) new physical facilities or extensive modifications shall require the prior approval of the funding agency;

(c) capital equipment for existing programs which costs more that $10,000 (1983/84 costs) and

which requires additional personnel for its operation shall require the prior approval of the funding agency;

(d) in no event shall an institution's expenditure of retained savings commit or obligate the funding agency to provide additional operating funds in subsequent years on account of such expenditure, whether by way of personnel, supply, maintenance, or other costs.

(vii) The balance of the savings not retained any year by institutions (i.e., 25% of second $50,000; 50% of balance) shall not be returned to the funding agency but shall be provided to a provincial research foundation to be established.

(viii) The incentive program shall be reviewed annually by a joint committee of the funding agency or agencies and the Newfoundland Hospital Association for the purpose of determining whether such incentive program is operating effectively, and a positive decision shall be taken annually to continue, discontinue or modify the program.

The ongoing review of the incentive program should also have the objective of eliminating or reducing any inequities apparent in the program, which inequities may be resolved through the expansion of the base budget review by government and through the development of performance indicators which enable quantity, quality and intensity of patient care to be related to incurred costs.

(ix) When choices exist between facilities for expansion, program additions or other enhancement, and when otherwise consistent with rational planning, the decision be made in favour of the facility exhibiting the best quality/cost performance record.

4.67 Government and the Newfoundland Hospital Association jointly develop suggested minimum qualifications for hospital and nursing home financial managers, together with suggested minimum requirements for internal reporting systems, both varying as appropriate by institutional size and complexity. It is further recommended that the Newfoundland Hospital Association develop continuing education programs for financial managers and that such programs be mandatory for all financial managers in the year of appointment and every three years thereafter. It is further recommended that hospital and nursing home boards be encouraged to adopt the qualifications developed as minimums and that existing personnel be required where necessary to upgrade their skills to a level equivalent to that stipulated by each board.

Capital Funding

4.68 The outright grant system for capital expenditures be continued.

4.69 A minimum amount of funding for capital expenditures be made available to each hospital annually, calculated on the following basis:

1.0% of the first $10 million operating budget exclusive of education costs; plus

0.75% of the balance of the operating budget exclusive of educational costs.

It is intended that such funding be a guaranteed minimum, and that funds from agreed cost-sharing arrangements would be in addition to such minimum.

4.70 With the prior approval of the Department of Health, hospitals be permitted to amortize the cost of capital expenditures against operating expenses over an agreed payback period, and that such amortization be permitted either through the appropriate allocation of the capital cost (i.e., purchase) or through annual lease costs.

4.71 Up to a cost of $10,000 and unless additional operating funds are required for such equipment, and subject to Recommendation 4.70 above, hospitals be permitted to purchase new and replacement equipment without the prior approval of the Department of Health.

4.72 The current cost-sharing programs between the Department of Health and hospitals for capital expenditures be continued and expanded.

4.73 Excluding financing for major capital projects, capital funding for hospitals for the three (3) fiscal years ending March 31, 1987, not be less than $6 million in 1984/85, $7 million in 1985/86, and $8 million in 1986/87.

Labour Relations

4.74 The existing labour relations protocol between the Government and the Newfoundland Hospital Association remain generally as presently structured, but that the present system of concluding one collective agreement for all employers of employees in a particular bargaining unit be modified to permit recognition of the

differences that exist between hospitals and nursing homes and between institutions of differing size. It is recommended that a separate employer group consisting of all nursing homes and hospitals of less than one hundred beds be formed and that the employer's negotiating committee receive advice and direction from this group concerning "size-related" collective agreement provisions. It is further recommended that such "size-related" provisions be identified and that separate majority ratification of such provisions by such employer group be required before the provisions are binding on those employers.

4.75 The principle of negotiating "local condition" provisions to meet the needs and concerns of particular individual employers and/or union locals be accepted. Provisions which are reasonably requested to accommodate variances in local conditions should preferably be negotiated at the request of either the specific employer or union local during the provincial negotiations. As an alternative, however, it is recommended that either an individual employer or union local be permitted to give notice to the other individual party and to the provincial components a minimum of 120 days prior to the expiration of the relevant collective agreement that it will no longer be bound by the provincially negotiated clause in question and that it wishes to negotiate the same with its own individual local or employer, as the case may be. If notice is given, neither the institution nor the local will be bound by the provincially negotiated clause and will proceed to negotiate their own clause. Until such clause has been negotiated, no collective agreement will be considered as being in place, and the full range of remedies for failure to conclude an agreement would be

available to both parties. It is further recommended that, if this recommendation is accepted and implemented, the appropriate provincial employer and employee representatives develop a schedule of clauses amenable to local condition variances and that only clauses included on such schedule be available for individual negotiations.

4.76 The principle be accepted that an employee's net pay should not be increased by virtue of being in receipt of Worker's Compensation and that the appropriate collective agreement or legislation changes be instituted to preclude this.

4.77 The classification and pay system, insofar as it provides for group classification reviews and appeals therefrom, not be available to bargaining unit groups independently of the collective bargaining process.

4.78 The "minimum staffing" collective agreement provision at the Waterford Hospital be eliminated as a negotiable item.

4.79 A provincial study on sick leave and sick leave benefits in hospitals and nursing homes be conducted and completed within twelve months of acceptance of this recommendation by an independent individual or individuals, to study and where appropriate, make recommendations to Government, the Newfoundland Hospital Association and Labour on at least the following:

(i) a detailed analysis of sick leave including sick leave by institution, by employee group, by duration and timing of absence and such other parameters as may be thought relevant;

(ii) an assessment of the incidence of sick leave (either high or low) in specific institutions and in hospitals and nursing homes generally in comparison to other individual institutions and to both the public and private sectors, and identification of the reasons for such differences, if any;

(iii) an assessment of the degree to which, if any, the present sick leave benefit is being utilized for purposes other than sickness;

(iv) an assessment of the success or otherwise of the various methods instituted by employers to limit or reduce the amount of sick leave;

(v) recommendations on alternatives or modifications to the existing sick leave benefit provisions if it is concluded that such provisions are no longer appropriate.

4.80 For the period ending March 31, 1986, those provisions of collective agreements having a direct or indirect cost impact, other than salaries and wages, be maintained at their present levels, except for agreed modifications achieved through the mechanisms outlined above for specific provisions relating to smaller institutions generally or specific local conditions.

Note to Recommendations 4.74 to 4.80

It is recognized that the implementation of some of the preceding recommendations will require either the agreement of management and labour or the introduction of legislation. The

Commission hopes that joint recognition of the challenges facing the health care delivery system will enable management and labour to cooperate in implementing the recommendations.

Public Tendering and Local Preference

4.81 Board-operated hospitals and nursing homes not be made subject to provincial legislation concerning public tendering or local preference purchasing.

Management Engineering

4.82 Existing management engineering services be expanded to provide reasonable access to such services by all hospitals and nursing homes, and that in expanding the services in St. John's, consideration be given to expanding the services now available at the General Hospital rather than to creating separate services elsewhere. Outside St. John's, such services should be developed and made available on a regional basis.

4.83 Information compiled by and systems developed through management engineering studies at individual institutions be available routinely to the Newfoundland Hospital Association and to its member institutions.

4.84 The additional funding required for expanded shared and regional management engineering services be separate from the normal operating budget of the parent institution and that there be no charge made for institutions utilizing such services.

4.85 Each management engineering service be evaluated annually by a joint committee of the Department of Health, Newfoundland Hospital Association, the parent

institution and two institutions of the appropriate region to assess the effectiveness and productivity of the service and to take annually a positive decision on whether to continue, discontinue or modify the service.

Research and Development

4.86 A provincial research foundation be established to provide funding and support for research and development related to the health care field, including but not limited to clinical research and development, organizational research and development, and health care delivery systems research and development.

4.87 Funding for such foundation be derived primarily from non-retained institutional savings and sources other than direct Government funding, provided that in any given year should the total gross income accumulated by the foundation since its inception be less than $200,000 times the number of years since the foundation's inception, Government should provide sufficient direct funding to the foundation to bring the total accumulated gross income up to such amount.

4.88 Of the funding commitments made by the foundation in any three-year period, a minimum of 50% of the funds so committed be allocated to research and development of health care delivery systems (i.e., nonclinical health research).

4.89 The foundation be reviewed annually by a joint committee of the Department of Health, the Department of Social Services, Memorial University Faculty of Medicine and the Newfoundland Hospital Association for the purpose of determining whether or not the foundation is meeting its

objectives and is still required. Should the foundation be discontinued, future non-retained savings shall be returned to Government.

Routine Diagnostic Testing

4.90 All hospitals immediately conduct a critical review of all admission protocols, preoperative testing protocols and other standing orders in order to assess the continued need for such tests after taking into account costs, clinical benefit and ease of ordering on an "as medically required" basis.

4.91 All hospitals conduct such reviews at least annually.

4.92 All hospitals be required to accept as a matter of principle and policy their role in monitoring individual physician practices in use of diagnostic facilities, and that such monitoring role consist of providing on a timely basis, information respecting the testing practices of individual physicians to a peer review body.

4.93 Physicians not on the medical staff of the hospital but referring in diagnostic work to such hospital be required to apply for renewable "diagnostic service privileges", the grant of which privileges will consider the hospital's ability to perform additional diagnostic procedures, and the renewal of which privileges will consider that physician's utilization pattern.

4.94 The necessary budgetary flexibility be provided to permit the capital costs of any information system necessary to implement the foregoing recommendations to be amortized over a reasonable period of time against operating expenses, and that such information system be

developed to serve multiple rather than individual institutions.

4.95 Hospitals increase programs designed to improve medical staff awareness of the cost of diagnostic testing.

4.96 Except where referrals are within an institution and will not generate an additional independent patient record, all referrals to specialist physicians (either inpatient or outpatient) include with the referral request copies of all reports of diagnostic services performed on such patient within the last thirty (30) days, and that where such patient is hospitalized under the care of the specialist physician, the reports so forwarded form a part of that patient's permanent medical record.

4.97 All hospitals providing specialist services establish a peer review mechanism whereby the diagnostic services performed on referred patients are reviewed on an audit basis to assess whether or not unnecessary or redundant diagnostic work is being performed at the referral institution.

Nursing Education

4.98 A joint committee of the Department of Health and representatives of the four hospital schools of nursing be convened immediately to establish uniform standards of clinical and classroom instructor hours per student, and that the committee be required to establish staffing levels for instructors which will reduce the total provincial costs for clinical and classroom instructors by a minimum of $350,000 annually.

4.99 Commencing in September 1984, the monthly stipend for nursing students in the first and second years be eliminated.

4.100 Commencing in September 1984 for nursing students entering their first year, and thereafter, students in their first and second years be required to pay an annual tuition fee to be established as a uniform fee agreed jointly by the Department of Health and the schools. It is not intended that this recommendation apply to students presently in training, but rather to those commencing their training in 1984 and beyond. It is also suggested, without recommending, that such tuition fee be not less than $500 per year.

4.101 The rates presently charged nursing students (and others) for residence facilities and meals be immediately reviewed by the Department of Health and if necessary increased with a view to ensuring reasonable cost recovery and an equitable comparison with rates charged by other educational institutions for equivalent services.

4.102 No endorsement be given by Government of the BN requirement for all nurses by the year 2000 until the fullest discussions have been held between all concerned with such endorsement, and that such discussions include representation from the hospitals, the hospital schools and practising physicians, and that such endorsement be given only if the requirement has been established to be necessary to meet the nursing needs of the citizens of the Province.

4.103 The hospital schools and Memorial University expand to the fullest extent possible the present program of

providing university credit courses to hospital nursing students.

4.104 Government, in consultation with the Council of Nursing Assistants, the Newfoundland Hospital Association and the training institutions, review the training of Certified Nursing Assistants in the Province with a view to meeting provincial needs only through one educational institution. The Commission suggests, without recommending, that such institution be the College of Trades and Technology.

The Waterford Hospital

4.105 Government continue to give priority to the development of a comprehensive and integrated network for the diagnosis, treatment, care and rehabilitation of the psychiatrically ill that ensures access to appropriate service to all citizens of the Province.

4.106 Regional community-based support services be further developed so that services are provided closer to patients and their families.

4.107 Such regional community-based support services be funded and provided through the regional long-term care board recommended by the Commission in order to ensure fullest coordination of available services and to avoid duplication.

4.108 Government endorse and accept the program developed by the Waterford Hospital and the National Institute on Mental Retardation for the deinstitutionalization of mentally retarded adults.

4.109 A formal liaison committee be formed between the Waterford Hospital and representatives of those general hospitals providing dedicated psychiatric inpatient units in order to promote a fuller understanding of the demands placed upon and the difficulties experienced by each facility, and further that no permanent or temporary addition to, reduction or modification of any psychiatric service offered by a general hospital be put into effect until such modification has been discussed in full by the liaison committee.

Rationalization and Coordination

4.110 As a principle and policy, the Departments of Health and Social Services adopt the concept of multi-unit management for hospitals and nursing homes in the same geographic area. Such geographic area may be a region such as the Burin Peninsula, but may also be a community area such as Grand Falls, Corner Brook, Bonavista, St. Anthony, etc. This recommendation envisages the management of two or more institutions under one Board of Management but does not require for its implementation one source of funding for all institutions. It is further recommended that where multi-unit management is implemented, separate global budgets be provided for each individual facility or unit, with the proviso that at the discretion of the board and with the approval of the funding agency, funds may be transferred between such global budgets.

It is not recommended that the multi-unit concept be applied to the St. John's area other than for Hoyles Home and Escasoni Home.

4.111 The Departments of Health and Social Services together with institutional representation jointly identify the areas and institutions under Recommendation 4.110 that are felt to be appropriate for multi-unit management, and that each institution so designated be formally advised to this effect.

(i) The Commission recommends that the following institutions be designated as appropriate for multi-unit management designation and operation by a single board (or committee if under a regional board):

(a) Western Memorial Hospital, Corner Brook Interfaith Nursing Home, Bonne Bay Hospital, Burgeo Hospital;

(b) Sir Thomas Roddick Hospital, Bay St. George Senior Citizens' Home;

(c) Central Newfoundland Regional Hospital, Carmelite House, Harbour Breton Hospital, Buchans Hospital, Botwood Hospital;

(d) James Paton Hospital, Lakeside Homes;

(e) Bonavista Hospital, Golden Heights Manor (under a regional board);

(f) Burin Hospital (new), Blue Crest Interfaith Home, any clinics on the Burin Peninsula;

(g) Carbonear Hospital, Carbonear Interfaith Nursing Home, Harbour Lodge, Old Perlican Hospital.

(ii) The Commission further recommends that the following regional boards be expanded or created:

(a) Grenfell Regional Health Services - to include Captain William Jackman Hospital, Port Saunders Hospital and Harry Paddon Memorial Nursing Home;

(b) Gander - to include Twillingate Hospital;

(c) Grand Falls - to include those facilities outlined above and North Haven Manor, Lewisporte;

(d) Clarenville - to include hospitals and nursing homes on the Bonavista Peninsula and any clinic facilities at Come by Chance.

4.112 Until Recommendation 4.110 is implemented in all areas of the Province where multi-unit management is identified as being feasible, formal liaison committees be set up in each such area consisting of equal representation from the institutions in the area, chaired by an independent community member not presently on the board of any participating institution. The role of such committee will be to identify, examine, and recommend to its constituent organizations opportunities, both short-term and long-term, for rationalization, coordination and sharing of services, including "hotel" services, clinical services, professional services, and administrative services.

4.113 Such committee meet at least monthly during its first year of operation and at least quarterly thereafter until full multi-unit management is in place, and that full minutes of each such meeting be recorded and copies

of same forwarded to the Departments of Health and Social Services within forty-five (45) days of such meeting.

4.114 For the period commencing immediately upon receipt by the institution of its designation as being appropriate for multi-unit management, and concluding on the date of the first regular meeting of the committee referred to in Recommendations 4.112 and 4.113, the institution concerned not be eligible for any budget incentive payment. Where any institution would otherwise be eligible for a budget incentive payment but for this recommendation, that payment shall be reduced pro rata by the proportion which the above period of time is of the total period of time on which the budget incentive payment would otherwise have been calculated.

4.115 Any institution which accepts any provincial responsibility as a tertiary care referral facility have a minimum of two (2) members of its Board of Management resident outside the greater St. John's and Eastern Avalon districts. (Districts to be as defined by the Department of Health.)

4.116 The St. John's Hospital Council be charged with the mandate of developing a comprehensive plan for the delivery of health care services in St. John's in accordance with the recommendations following, and that for the purpose of carrying out such a mandate:

(i) the Council membership be expanded to include one representative of consumers, one representative resident outside the greater St. John's and Eastern Avalon district, and one representative of the St. John's branch of the Newfoundland Medical Association;

(ii) commencing immediately and subject to these recommendations, continuing for a minimum of three (3) years, Government provide to the St. John's Hospital Council sufficient operating funding to identify and evaluate the immediate, short-term and long-term opportunities for rationalization, coordination and sharing of services, to formulate recommendations for action and to assist in the implementation of accepted recommendations;

(iii) included in such funding be an amount sufficient to fund the employment of one resource/planning position, and necessary clerical support, if any, at each of the General, St. Clare's, Grace, Waterford and Janeway Hospitals, with the position at the Janeway assuming responsibility for the Children's Rehabilitation Centre. Such position should be a joint appointment of each hospital and the Council, and is intended to work primarily out of each individual institution in a fulltime planning and liaison role with the Council.

4.117 A comprehensive plan for the rational delivery of institutional or institution-based services in St. John's until at least 2000 be developed by the Council and agreed upon by the above institutions and Memorial University Faculty of Medicine, and that such comprehensive plan have at least the following principles and objectives:

(i) the provision of the highest quality and widest range of clinical services possible, after

considering economic size of units, technology, manpower, and other resources required;

(ii) a matching of the level of medical need with the level of facility and care provided, including consideration of hostel units, short-stay units, day care programs and home support programs;

(iii) the establishment of guidelines both for the minimum service levels required to support new technology, clinical programs and specialized support disciplines, and for the location of such technology, programs and disciplines in order to ensure access to such based on need while preventing duplication;

(iv) the recognition of the present identity and contribution made by the above institutions and preservation of such identity through innovative organizational and physical structures, but only insofar as such preservation is consistent with and assists in obtaining the other objectives outlined above.

4.118 Such comprehensive planning consider the clinical, educational and economic viability of continuing to fund as freestanding institutions the Janeway, Grace, St. Clare's and Children's Rehabilitation facilities, and that the clinical, educational and economic (operating) consequences of operating two or more of these organizations in a combined physical facility be assessed. Examples only of such combination would be a single facility housing the Janeway, Grace and St. Clare's, and the linkage of the Children's Rehabilitation Centre with either the Janeway or the Miller Centre.

4.119 Such plan be formulated within the following parameters:

(i) the number of acute short-term general hospital (including pediatric) beds up to and including the year 2000 not exceed in total the present complement of 1,185 (General, 331; Grace, 310; St. Clare's, 314; Janeway, 230);

(ii) major construction, expansion, renovation or modification be permitted at a maximum of two (2) sites;

(iii) a final agreed plan be submitted to Government by December 31, 1985, such plan carrying with it the support of a majority of the membership of the St. John's Hospital Council, included in which majority must be each of the General, Grace, St. Clare's, Janeway, and Waterford Hospitals, Children's Rehabilitation Centre and Memorial University of Newfoundland Faculty of Medicine. Failing such agreement by December 31, 1985, a final plan should be submitted to Government by March 31, 1986, such plan carrying with it the support of a majority of the membership of the St. John's Hospital Council, included in which majority must be at least five (5) of the foregoing seven (7) institutions or agencies. Failing submission supported by such majority by March 31, 1986, that Government withdraw funding from the St. John's Hospital Council effective April 1, 1986, and assume full responsibility for the planning process.

4.120 Until such comprehensive plan is developed, agreed upon by the institutions concerned, Memorial University

Faculty of Medicine, and the Council, and is submitted to Government, no expenditure for expansion, or significant expenditure for renovation or modification, or for the study or planning of same be allocated or approved for the institutions concerned.

4.121 For the three (3) fiscal years commencing April 1, 1984, the <u>total</u> budget for the General Hospital, St. Clare's Mercy Hospital, Grace General Hospital, Janeway Child Health Centre and Children's Rehabilitation Centre be frozen at the 1983/84 approved budget level, excluding funding for educational programs as identified on the 1982/83 Annual Return of Health Care Facilities, Hospitals (Part 1, page 11, lines 01-07) with the exception that negotiated and authorized salary rate increases and other negotiated or resulting benefit increases be provided by Government, and with the further exception that during such three-year period, funding for hospital-based and home renal dialysis service be provided on an agreed basis which reflects the actual variable cost of providing the service during each year.

4.122 During such three-year period, hospitals providing referred in diagnostic services for other institutions be permitted to charge and collect from those institutions a fee for such services which reasonably reflects the marginal cost of providing such services.

4.123 During such three-year period, funds may be reallocated between the institutions concerned, the intention being that only the <u>total</u> funds for the City be frozen, with the exception as noted above.

User Fees

4.124 Effective April 1, 1984, the $5 per day user fee be abolished, with the proviso that fees incurred prior to that date remain as liabilities until paid.

Health Technology

4.125 Each hospital create a standing committee on technology, with subcommittees on clinical technology and nonclinical technology, such committees to include medical, laboratory/radiology and management representation, the role of such committee to be to review requests for significant expenditures on new technology and to make recommendations to the board concerning same, having taken into account at least the following factors:

(i) the marginal benefit, clinical or otherwise;
(ii) the marginal operating cost;
(iii) the restrictions on use which should be imposed, if any;
(iv) the availability or planned availability of similar technology in the Province;
(v) the alternatives available, if any;
(vi) the priority of acquisition.

4.126 The feasibility be explored of using the currently existing telemedicine system as a means of transferring laboratory reports and other medical information within the Province.

4.127 Government appoint a committee of representatives from Newfoundland and Labrador Computer Services, the Department of Health, the Faculty of Medicine, and the

Newfoundland Hospital Association to maintain a "watching brief" on the development of computer and telemedicine resources which could be used in the transfer of medical information between institutions in the Province, and to oversee the introduction of computer and data communication services within the health care institutions of the Province in order to ensure optimum compatibility and appropriateness of such services.

4.128 The Faculty of Medicine be requested to maintain a "watching brief" on the development of the role of telecommunications in the development of diagnostic procedures within the Province, and where indicated undertake cost benefit studies and recommend implementation of changes in service, and that as appropriate such "watching brief" be coordinated with that of the committee referred to in the preceding recommendation.

4.129 The use of the telephone consultation as part of the health care delivery system be encouraged and facilitated. (See also Recommendation 4.130.)

Physician Remuneration and Incentives

4.130 The Department of Health, the Newfoundland Medical Association and Memorial University of Newfoundland Faculty of Medicine jointly conduct a critical review of the physician fee schedule for non-institutional services, with a view to modifying the current fee-for-service structure:

(i) to encourage physicians, and in particular general practitioners, to consult wth specialist physicians

to the fullest extent possible prior to either hospitalizing or formally referring the patient; and

(ii) to reflect the amount of time clinically required by each patient visiting a physician.

4.131 Hospital boards ensure that adequate mechanisms are in place for timely and comprehensive peer review of clinical utilization, and that maintenance and renewal of physician privileges be conditional upon achieving and maintaining a practice pattern which is both clinically and economically acceptable.

4.132 A selective capitation method of remuneration for services provided by family physicians to patients age 65 and over be initiated as a pilot project for a minimum of three (3) years, such method to be offered to either all or a selected group of current fee-for-service family physicians, provided that a minimum study group of fifty (50) physicians is available.

4.133 In setting of the fee schedule for various categories of physicians, provincial manpower needs be accepted as a dominant factor, and that the fee schedule be used as a mechanism to influence the supply and location of various categories of physicians. It is further recommended that the Department of Health and the Medical Care Commission accept a greater role in the specific fee schedule allocation to ensure that such allocation is responsive to provincial needs.

4.134 The Faculty of Medicine be encouraged to increase its curriculum content on physician accountability for economic use of resources.

Emergency Services

4.135 The Department of Health, Newfoundland Hospital Association and Newfoundland Medical Association jointly develop and conduct a public education program on the appropriate and inappropriate use of the hospital emergency department and on the alternative avenues of care available.

4.136 Family physicians in group practice be encouraged to expand the availability of physician coverage during the evening, night and weekends, and that consideration be given to utilizing the physician fee schedule to assist in improving the range of comprehensive and continuing care available from family physicians.

4.137 The St. John's Hospital Council, as part of its mandate under this report to develop a plan for the provision of health care services in St. John's, give serious consideration to the need for the number of fully functioning 24-hour emergency departments which presently exist in the City of St. John's.

Ambulance Services

4.138 The Department of Health proceed with its intention to undertake a thorough review of the ambulance service needs and programs for this Province, and that methods and controls be established to ensure that ambulance services are used only when clinically required.

New Modes of Service Delivery

4.139 Provincial health policy be formulated to encourage the development of health services on the basis of five major modes of health care delivery:

1. hospital inpatient services;
2. nursing homes;
3. home support/home care services;
4. the extended role of the hospital;
5. the clinic.

4.140 Provincial health policy accept and require maintenance of excellent communication and coordination between each of the five major modes of service.

4.141 Provincial health policy stipulate that for each individual patient and problem, the necessary health services be provided through those modes of service which are economically most efficient, and clinically most effective.

4.142 Hospitals investigate means to provide outpatient diagnostic services on a prompt and coordinated basis with the objective of eliminating all unnecessary diagnostic admissions. It is suggested that this be achieved either through the recommendations following or by one or more hospitals conducting a one-year pilot project providing central access to and booking of outpatient diagnostic services.

4.143 Hospitals larger than one hundred beds jointly investigate with the Faculty of Medicine the feasibility of commencing one or more Ambulatory Clinical Management Units and Day Wards as a clinically appropriate and

cost-effective alternative to admission. It is suggested that a minimum of two (2) one-year pilot projects be instituted, with the operating funding for such projects being provided from the normal operating budget of the institution, and the research and data collection component of the funding being requested from the provincial research foundation.

4.144 All hospital boards review the objectives or mission statement of their hospital with a view to ensuring that, insofar as it is clinically appropriate, the extended role of the hospital is recognized and supported to the fullest extent.

4.145 Where overnight accommodation is provided in hospital for reasons of transportation and/or geography, consideration be given to charging for such accommodation at a rate comparable to those charged for hostel accommodation.

4.146 Government refrain from establishing further solo practice salaried family practice positions in this Province.

4.147 Government encourage and facilitate the development of salaried group practices within the present salaried rural family practice services of this Province. These can arise by expansion of current practices or by combining adjacent practices.

4.148 Government encourage and facilitate the provision within rural clinics of those diagnostic and therapeutic services which have been proven to be both practical and appropriate for such sites.

4.149 Government encourage and facilitate the placement of related service individuals within the same building as that occupied by the rural salaried family physicians. These would be offices for public health nurses, social workers and the local home support/home care program.

4.150 Government strive to ensure that individuals entering independent family practice in Newfoundland are adequately and appropriately trained for this branch of service.

Community Health Centres

4.151 Three community health centres be established, and that these be located in Baie Verte, Botwood, and Mount Pearl.

4.152 Funding be provided to permit a thorough study of the effectiveness of these three community health centres.

4.153 The resources of Memorial University Faculty of Medicine be utilized to assist in the design, development, operation and study of the centres.

4.154 Each centre be permitted to operate at its designed potential for a minimum of three years and that at the expiration of such period a positive decision be taken by government, in consultation with the body responsible for each centre, the Faculty of Medicine, and hospital and nursing home representatives to continue, discontinue, or modify the operation of the centre.

4.155 The Faculty of Medicine be encouraged to continue to review the optimum modes of delivery of primary care, having due regard for the effect of the pattern of

primary care services on the utilization of other modes of service delivery.

Northern Medicine

The following thirteen recommendations are applicable only to the northern region of the Province.

4.156 Those health care facilities located within the northern region which are not currently part of the Grenfell Regional Health Services program be transferred to that board. These include:

Port Saunders Cottage Hospital;
Interfaith Nursing Home, St. Anthony;
Harry Paddon Memorial Nursing Home, Goose Bay;
Captain William Jackman Hospital, Labrador City.

(NOTE: This is a repeat of Recommendation 4.111 and is included here for convenience.)

4.157 The Grenfell Regional Health Services Board in association with the communities it serves establish at least six local advisory committees to facilitate communication between the Board, its central administration, and the citizens of the areas represented by each committee.

4.158 An additional specialist be added to each of those specialty practices currently situated in St. Anthony in which the nature of medical practice is such that there is need to provide frequent emergency specialty services and also the need to provide daily complex specialized care to hospitalized patients.

4.159 The medical services provided by paired consultant specialties at St. Anthony include the provision of regular consultant visits to other health care sites in the northern region.

4.160 A family practice group practice be established in association with the Charles A. Curtis Memorial Hospital at St. Anthony. In addition to providing services to that community, these family physicians would also provide regular clinic services at satellite clinics located in other nearby communities. Initially this should include three fulltime family physicians or the equivalent.

4.161 The necessary modifications be made to the St. Anthony hospital to provide clinic and office space for the additional specialists and family physicians stated in Recommendations 4.158 and 4.160 above.

4.162 If any solo practice outpost nurse position exists, it be converted to at least a paired practice, either by enlargement or by transfer to an adjacent site.

4.163 Within the northern region, any solo general practice/family practice position which exists be converted to at least a two-doctor practice. Where the population to be served is so small that this is unreasonable, the position should be supplemented by the presence of at least two outpost nurses.

4.164 High priority be given by Government and the Grenfell Regional Health Service Board to the continuous presence of emergency anaesthesiology and emergency surgery

services at Goose Bay and Labrador City, as well as the availability of continuous comprehensive family practice services.

4.165 The funding of the Grenfell Regional Health Services include the funding of a dedicated medical air transportation and air ambulance service as an integral portion of the program of that Board.

4.166 Where possible, the necessary air transportation of patients within the northern region be provided through the established medical air transportation service within the northern region, at reduced cost to the patient.

4.167 The cost to the individual of medically necessary air transportation within the northern region be subsidized when it involves the receipt of necessary medical service at a site within the northern region.

4.168 The cost to the individual of medically necessary air transportation outside the northern region be subsidized only after certification by the Grenfell Regional Health Services Board or its delegate that the required service was not available within the northern region when required.

4.169 That the subsidization mentioned in the preceding recommendations be such that the individual will be required to pay an amount equal to that payable by each recipient of ground ambulance services elsewhere in the Province.

RECOMMENDATIONS INCLUDED IN CHAPTER 5
THE PROVISION OF LONG-TERM CARE SERVICES

The Commission recommends that:

5.1 Effective April 1, 1984, one universal rate of $1,200 per month be established for all private paying nursing home residents, and that this universal rate be applied to all Interfaith and Government-operated nursing homes.

5.2 The universal rate so established be subject to annual revision.

5.3 Where imposition of this universal rate as of April 1, 1984, will mean for any individual an increase in the monthly rate of greater than 30%, the transition to the universal rate be phased in over a period not to exceed two (2) years; i.e., payment of the full universal rate no later than April 1, 1986.

5.4 The rate for those residents presently paying more than the universal rate be reduced immediately to the universal rate.

5.5 For those residents presently paying less than the universal rate and subject to Recommendation 5.3, the rate be increased by 50% of the differential on April 1, 1984, and the remaining 50% on April 1, 1985.

5.6 Long-term care patients in hospitals who are medically discharged be charged a rate equivalent to 75% of the universal rate applied to nursing homes.

5.7 The funding agency, in consultation with the nursing homes, develop a mandatory system for ensuring financial accountability, including consistent accounting practices, comprehensive statistical compilation, and timely reporting to the funding agency of prescribed management information which will allow accurate determination of the performance of each nursing home and meaningful comparisons with the performance of other homes.

5.8 The funding agency, in consultation with the nursing homes, develop budget norms for the major expenditure categories and fund the operating budgets on the basis of such norms, allowing deviations only when there is clear and compelling reason to permit a different figure in any particular situation.

5.9 Budgets for nursing homes be administered on a global basis by the funding agency on a basis similar to that now used for hospitals, and that any and all payments from residents be treated as 100% offset shareable income. This recommendation should be implemented only if:

(i) proper norms and standards are established and implemented;

(ii) appropriate controls and monitoring mechanisms are established;

(iii) the regional assessment and placement function is implemented.

5.10 Hoyles Home and Escasoni Home be transferred from direct Government operation to a single community board, with the proviso that the role of both facilities continue to be directed toward the highest level of nursing care available in the Province's nursing homes, and with the further proviso that one or both facilities be required as part of their mandate to accept for admission patients requiring high level nursing home care on an emergency basis and for whom an appropriate level of care is not otherwise available.

5.11 A liaison group be formed consisting of one board member and one senior staff member of each St. John's nursing home, the mandate of each group being to review regularly the role of and services provided by the nursing homes, and to investigate and assess the potential opportunity for improving services through sharing and pooling of staff, facilities, and other resources.

5.12 Immediate steps be undertaken to determine the capacity of the present nursing home system to accommodate Level II and Level III nursing care residents. If some homes can be renovated, efforts should be made to determine the cost of such renovations relative to building new facilities or adding on to existing nursing homes.

5.13 The four-year plan of the Department of Social Services be implemented except that it be reviewed to give consideration to regional disparities in terms of the distribution of nursing home beds.

5.14 The norm of 40 beds/1,000 persons aged 65 and over be accepted as a target and used as a planning tool in the future.

5.15 Plans be developed for the construction of 700 new nursing home beds to accomodate Level II and Level III nursing residents in accordance with the 40/1,000 norm.

5.16 A comprehensive review be carried out of drug distribution and control at nursing homes and licenced boarding homes, such review to include consideration of the appropriate role of Central Pharmacy.

5.17 Regional assessment teams be established to assess, according to provincially established criteria, the needs of individuals requesting admission to long-term care facilities, such teams to include a physician, a social worker, a representative of the nursing homes in the region, and representatives of the Departments of Health and Social Services.

5.18 Authority for placement of nursing home residents be vested in the regional long-term care boards with provision for nursing home input and consideration of resident preferences.

5.19 Long-term care boards be established on a regional basis to coordinate and facilitate the delivery of home support programs and services throughout the region, and that such boards assume the responsibility for the provision of all home support services in the region, for the regional assessment teams to be instituted, and for the placement of residents of the region requiring long-term institutional care.

5.20 The regional long-term care board be the only body funded by Government for home support services.

5.21 Regional promotion programs be developed to inform the various communities within the region of the availability of home support services and the means to access those services.

5.22 Home support services be provided free of charge to all those assessed as requiring those services.

5.23 In recognition of the need to keep the elderly out of institutions as long as possible, Government allocate a minimum of an additional $1 million to home care programs, such funds to be increased as programs develop in the regions.

5.24 Government develop a comprehensive policy on long-term care. This policy should encompass home care, home support and all institutionally-based services for those people requiring long-term care.

5.25 Government establish a long-term care policy committee composed of senior representatives of appropriate departments of Government.

5.26 Regional psychogeriatric units be established in specified nursing homes or hospitals by either adding on to the present physical facilities or by renovating space in order to accommodate the special needs of these residents.

5.27 Regional home support programs be given the mandate to establish home support programs directed toward the family who cares for confused and demented elderly

relatives at home. This would include short-term respite care, day care, and regular relief in the household.

5.28 The specified psychogeriatric units be required to maintain a designated number of respite beds.

5.29 Ongoing continuing education in the care of the elderly be developed and be mandatory for nurses, nursing assistants, and other personnel in long-term care facilities.

5.30 Memorial University Faculty of Medicine be encouraged to develop a program in geriatrics.

5.31 The University and hospital-based nursing programs be encouraged to review their curricula with a view to improving the geriatric components of these programs.

5.32 While giving due regard to their freedom of choice, steps be taken promptly to de-institutionalize the physically disabled.

5.33 The regional long-term care boards be given the mandate and the funding to provide the appropriate community support in order to maximize the independence of the physically disabled so that their contribution to their community is optimized.

5.34 Comprehensive legislation be enacted to provide for the management and operation of nursing homes and long-term care in the Province.

5.35 A system of small supervisory homes called <u>Personal Care Homes</u> be established in the Province.

5.36 The number of residents be limited to six not including the "caring family".

5.37 These homes be licenced and monitored regularly to ensure proper standards are maintained.

5.38 These homes have access to regional home care/home support programs when necessary.

5.39 By April 1, 1985, jurisdiction for all nursing homes in the Province be transferred to the Department of Health.

5.40 Commencing immediately, and with particular emphasis on the development and allocation of 1984/85 nursing home budgets, there be significant involvement of the Department of Health in all major decisions affecting nursing homes.

RECOMMENDATIONS INCLUDED IN CHAPTER 6
LEVEL OF FUNDING

The Commission recommends that:

6.1 The 1984/85 total budget allocation for all hospitals outside St. John's be established at the same level as the 1983/84 budget for all such hospitals, with adjustment only for salary and related benefit increases. It is the Commission's intention that only the total (i.e. system) allocation be frozen, and that within such allocation flexibility be afforded the Department of Health to accommodate increases or decreases in individual budgets necessitated by baseline reviews. Necessary operating budgets for new facilities should of course be excluded from this process.

6.2 Serious consideration be given to establishing the same total funding level for the 1985/86 fiscal year, with adjustment only for salary and related benefit increases.

6.3 The 1984/85 total budget allocation for all nursing homes be established at the same "system" level as the 1983/84 budget for all nursing homes, with adjustment only for salary and related benefit increases. It is the Commission's intention that only the total (i.e. system) allocation be frozen and that within such allocation flexibility be afforded the funding agency to increase or decrease individual budgets.

RECOMMENDATIONS INCLUDED IN CHAPTER 8
SERVICE LEVELS AND PROGRAM REDUCTIONS

The Commission recommends the following options for consideration by Government should it be financially impossible to continue services and programs at existing levels or recommended levels in view of the limited financial resources available to the Province:

8.1 Priority be given to providing present services and programs in the most cost-effective manner, including implementation of the other recommendations in this report, and in particular those directed to home support services.

8.2 Implementation of a freeze on expansions to hospital inpatient facilities, including not opening new facilities presently under construction in Clarenville and Burin.

8.3 Reduction of inpatient beds by Government stipulating a dollar target by region, and establishing a mechanism for agreement among hospitals in each region on the number, timing, and distribution of bed closures. In the event that agreement cannot be reached, each hospital budget should be reduced pro rata to generate the amount of savings required within the region.

RECOMMENDATIONS INCLUDED IN CHAPTER 9
FISCAL CAPACITY AND REVENUE GENERATION

The Commission recommends that:

9.1 The following options, in order of preference, be considered by Government as viable revenue-raising measures in the event that additional revenue must be generated to fund the health care system:

1. payroll tax (employer only);
2. personal income surtax;
3. corporation capital tax.

9.2 Regardless of what revenue generating mechanisms are used by Government, Government remain the sole primary source of funding (outside of donations, pledges and board funding) for the health care system.